Clinical Assessment in Children's Services

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CLINICAL ASSESSMENT IN CHILDREN'S SERVICES

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INTRODUCTION
BACKGROUND - WHY A PAPER ON ASSESSMENT?

The Children's Services Division of the Ministry of Community and Social Services was created with the intention of developing a rational, unified, and humane system of special services for Ontario's children. In order to determine the specific types of assistance each child and his family might require, it is necessary first to assess the problems presented, to formulate an understanding, and to explore possible options. Naturally up to this point this overall process of assessment has varied considerably in different ministries, social agencies, institutions and disciplines because of variation in:

- legislated mandate of ministries and services
- identified target population
- nature of the service provided
- professional orientation and tradition

This paper attempts to identify the basic common elements of the assessment process which can be found in professional practice in any field and to develop a framework for assessment which is congruent with the philosophy and mandate of the Children's Services Division.

Guiding Principles and Philosophy of the Children's Services Division

Some of the fundamental principles adopted by the Children's Services Division are:

- a view of each child as a unique person, rather than simply as a member of a category such as sick, deprived disturbed, abused, neglected, delinquent, retarded or handicapped
- emphasis on supporting rather than supplanting the family network
- equal and integrated access to services
- continuity of care
- minimal intervention
- least restrictive alternative
- accountability of service providers
- fairness and humanity
- involvement of affected persons in decision-making processes.

Recent Developments Within Programs

While a unified approach to assessment is a necessary long-term goal, the Division also must deal with a number of more immediate and short-term assessment-related issues. Various branches of the children's services system have current and pressing needs to develop or modify aspects of their programs. For example:

- "community-based" regional assessments by the Corrections branch are replacing Oakville Regional Assessment Centre
- the four-level observation/detention system is being implemented and will be involved in the assessment process
- local interagency coordination efforts continue to develop in a number of areas of the province
- four-phase treatment systems have recently been developed for youngsters with multiple problems
- the courts are looking increasingly to clinical services for assistance. In response to this trend, the Division created the Task Force on Family Court Clinics which has examined legal, clinical and administrative issues and produced guidelines in its report. Its offspring, the newly-formed Family Court Clinical Resources Committee, is available both to the Division and to communities and their service networks for consultation in planning appropriate court-related clinical services.
- the day nurseries system has developed guidelines for multi-disciplinary team assessment.
- the Division has produced a paper outlining a functional analysis of children's services which briefly describes the function of assessment within a wide range of service activities. The present paper presents somewhat of a broader definition of assessment which is not however incompatible with the functional analysis paper.

When is Assessment Needed?

Assessment as described in this paper is viewed as an essential precursor to major planning for changes in a child's situation. Such changes are usually tied to the arranging of new services; management plans or placement for the child. Therefore, an adequate and sufficiently comprehensive assessment should occur before arrangement of:

- placement outside the family

- o changes in placement (including foster care and adoption)
- o provision of treatment programs
- o provision of special day care programs
- o placement within the training school system
- o contracting for individualized management programs
- o funding decisions regarding placement or treatment programs.

It therefore follows that those persons who are in decision-making positions carry a responsibility for expecting good quality assessment work from those of us who are assessment providers. In their "gatekeeper" positions program directors, family court judges and senior staff in all services must demand that plans and suggestions follow logically from sufficient exploration and understanding of the functioning of the child and his family.

The Scope of this Paper

It is hoped that this paper can stimulate discussion within and between the various "service streams" and thus contribute to the development of a more unified approach to assessment which brings together the best of current thinking and practice. At the present time, child welfare, children's mental health, day nurseries and juvenile corrections are the major service streams which have been brought together in the Children's Services Division. This paper has been written with their varying traditions and responsibilities in mind. However, the paper is intended to be applicable for any other service stream which may join the Division in the forseeable future (e.g., mental retardation services), and for others which relate to the Division's population such as special education services and crippled children's services.

The appendices include an annotated bibliography, an example of formulation of a case, and a list of organizations and individuals who provided us with opportunities to discuss their views on assessment. Chapter Four, The Process of Assessment, contains a considerable amount of material organized by Dr. Elsa Broder for the University of Toronto's Child Psychiatry Program and we are particularly grateful for permission to adapt it. We also wish to acknowledge the value of comments and criticisms of an earlier draft which was circulated widely both in and outside the Children's Services Division.

CHAPTER 1:
PROBLEMS IN ASSESSMENT IN CHILDREN'S SERVICES

The Purposes of Assessment

The term "assessment" tends to be used as if it refers to a discrete and clearly identifiable procedure or entity that has a generally understood form and purpose. This is particularly so in settings where it is undertaken as a relatively standardized and routine procedure. However, in fact, processes of assessment are carried out for many different reasons and with many different approaches in the various service systems.

Some purposes of assessment:

- to gain a fuller understanding of a child and family
- to help a child and family obtain an appropriate service
- to enable an agency to decide how to help
- to address the complicated issues perplexing the service providers
- to determine the level of funding in day care
- to comply with the administrative demands of an organization
- to ensure that "no stone has been left unturned"
- to obtain further opinions as alternatives to those already considered
- to enable a service to accept or reject referred children
- to delay making a decision
- to pass on or share responsibility for decision-making
- to determine if a child's situation has altered since a previous contact
- to determine the degree of structure or security needed for a child.

These and other concerns can lead to the initiation of an assessment process. Some reasons may seem intrinisically "better" than others but, nonetheless, it is necessary to recognize that assessments meet needs of service providers as well as of children and families. It is therefore essential in each case to state with clarity the purpose or purposes which can be identified for the child, the family, the referring persons or agency, and the potential service providers. It is of questionable value to attempt to assess a child's functioning in isolation from the particular concerns of parents, teachers, physicians, Children's Aid Society (CAS) workers, probation officers, police officers, judges, lawyers, and other concerned parties.

General Problems of the Service System

The formation of the Division occurred in response to a number of problems arising from the fragmented system of service delivery. For example:

- The particular service obtained for a child is often determined by chance contact rather than upon his or her needs as seen in relation to the full range of possible services.
- Too many children become the total responsibility of public services, and stay too long and too deeply in "the system".
- An over-emphasis is placed on substitute care rather than on supplementation or support.
- Residential care dominates thinking about funding and planning.
- Services sometimes appear to be more concerned about their administrative needs than about the children they serve.
- Socioeconomic factors can bias the use of services, e.g., a financial needs test is required for provision of day nursery care to many non-handicapped children and negative labels follow them into the school system.
- Differing fundamental philosophies pertain, e.g., universality in health services and selectivity in social services.
- Problems abound in relation to standards, continuity of care, accountability, consistency in policy and procedures, and consistency in quality of service.
- Increased identification of complex cases is evident, e.g., "multi-problem", "multi-services", or "hard-to-place" children.
- Misleading or inadequate labelling occurs in order to obtain services.

Problems Directly Related to Assessment

Quantity/Availability:

- There is not enough assessment capability, at least in non-urban areas.
- Assessment resources, where available, are often not readily accessible, e.g., long waiting lists.

- There appears to be too much repeating of assessments.

Quality:

- Assessments are often narrow or simplistic in focus, e.g., lacking family, medical or educational information, concerned with behaviour but not underlying causes or situations, lacking in sufficiently broad knowledge or understanding of available services.
- Assessments are often poorly focused and unrelated to service provision, e.g., psychiatric or psychological assessments which are not oriented towards management or placement problems.
- Multi-faceted assessment is frequently fragmented and inadequately integrated.
- Assessments lack adequate case management.
- Routine assessments tend to become mindless procedures rather than thoughtful, dynamic processes.
- Problem-focused assessments risk missing important areas of functioning, e.g., many delinquent children are also found to have learning disorders.
- Distortion of assessment findings can occur when they are aimed at obtaining specific services, e.g., residential treatment.
- The assessment report or summary becomes confused with the assessment process.
- Anti-labelling attitudes are used as an excuse for unclear thinking.
- Lack of family involvement seriously limits the scope and depth of assessments.
- Lack of involvement of school services limits both assessment and possibilities for assistance.
- Assessment deliberations and findings are often not appropriately or sufficiently shared with children and families.

Service Agency Issues:

- Crisis-oriented action often takes precedence over adequate assessment of problems.

- Administrative needs of organizations often result in decision-making (e.g., placement) with little or no assessment and therefore with inadequate understanding of the problem.

- It has proven difficult to achieve consistency in approach, language and objectives among services and professionals.

- Assessments are duplicated because of difficulty in valuing and trusting the work of other agencies or professionals.

- Agencies have legal and clinical problems in sharing information with each other.

- A demand for reassessments can be misused as a screening-out process and a barrier to service.

- Requests by a newly-involved agency to carry out its own assessment may be motivated by a need to develop a relationship with the child and family rather than from a need for more information.

- Residential assessment centres may meet organizational needs for professional collaboration, but can render assessment of a child within his own familial/social context virtually impossible.

The above mentioned problems represent current concerns of persons and organizations involved in all areas of children's services. It is hoped that the paper will clarify some of the problems and provide a focus for the discussion which is needed in the service network.

Summary

This chapter has outlined the context and purposes for writing a discussion paper on assessment. It identifies general problems in the service system relevant to assessment and specific issues relating to assessment processes. Assessment is seen as having many possible purposes which need to be stated clearly in each instance and finally the chapter lists those purposes for which assessment is viewed as essential.

CHAPTER 2:
ASSESSMENT - WHAT DOES IT MEAN?

Dictionary definitions of "assessment" indicate that for centuries the term has been used in the estimation of taxable property, of possessions, or "any useful quality". It would seem to follow that when the term is applied to examination of an individual's personality and behaviour it refers to an accounting of particular qualities, including both assets and liabilities, strengths and weaknesses, achievements and failures.

There appears to be an increasing concern in the human service field that our training and official responsibilities can easily cause us to view an individual in terms of weaknesses and disabilities and to give insufficient attention to strengths and achievements. This dilemma and its unfortunate consequences are eloquently addressed by Nicholas Hobbs in The Futures of Children. His comments on superficial classification and labelling are of great importance to those providing services to children.

Some categories and labels are needed in order to know how many children require certain special services and these categories and labels can be useful in matching individual children to particular services, but they can also become misused in covert ways which degrade children and deny their humanity. This is particularly so when the child's presence in society is felt to be offensive or disturbing. Rejection and exclusion from the greater community becomes rationalized by placement in special residences for retarded, emotionally disturbed, physically disabled, and delinquent children. We are caught in a continual dilemma of struggling to evade the negative connotations which any type of classification, diagnosis, or labelling eventually seems to acquire.

Adequate assessment should lead to accurate classification, diagnosis or labelling and therefore to appropriate assistance or treatment. It is a professional responsibility to guard against inaccurate, vague, or derogatory labelling and to strive for clarity and precision. The misuse of labels which sometimes occurs does not justify sentimental or anti-professional rejection of classification and diagnosis.

Is assessment then a catalogue of a child's strengths and weaknesses, a collection of facts and figures? To a limited extent yes, because many factors must be considered in all areas of individual, familial and social functioning before needs can be appropriately met. However, in current practice in the human service field assessment goes beyond a mere cataloguing of facts and refers to a thoughtful process involving:

- collecting information

- making direct observations
- weighing the facts and developing hypotheses about the problems
- understanding the individual's needs and deficits
- estimating the nature and degree of assistance which can promote healthy functioning and continuing development
- arranging the provision of such assistance.

Such a process can be extremely complex and prolonged; it is often appropriate that it should be. This does not imply that assessment need by mysterious, since in many ways all human beings make assessments of people and situations without identifying the process in any formal sense. Assessment can be viewed as a basic human process which ranges from the brief and intuitive to the thorough and thoughtful. In assessing, we measure the facts or observations before us against our knowledge and experience. From this we then develop hypotheses and assumptions which guide us, whether intuitively, thoughtfully, or both, in the action which we then undertake. Throughout our day we make a multitude of brief assessments of such everyday issues as the weather, the traffic patterns, the behaviour of family and colleagues, and our own behaviour is guided by these assessments.

Then if assessment is really an everyday human activity why discuss it in detail and make such a fuss about it? The answer is because there is a need to distinguish between intuitive response and disciplined, thoughtful response. If any claim is to be made for professionalism it must surely be on the basis of a professional's ability to react to problems and people with an awareness of, and a creative balance between, both subjective intuition and objective knowledge. Therefore, the competent professional, while collecting facts and information from and about a person also reflects upon:

- his personal reaction to the information
- his personal reaction to the assessment process
- his professional knowledge and experience.

Furthermore, he (or she) attempts to differentiate between these as an understanding of the person and a plan for assistance is developed.

Another major difference between everyday reaction and professional assessment processes is the application of discipline to thinking in professional activity. This implies that there is some recognizable form and order to the assessment process by which the professional can demonstrate a logical flow of his or her collection of facts, observations and reactions towards the development of reasonable assumptions, appropriate classification or diagnosis, and relevant plans for assistance. While such a procedure might vary in underlying theory and technique in different professions or services, the common elements identified above are essential to any assessment.

In earlier paragraphs assessment is described as a process. Unfortunately, there is a common tendency to attempt to identify it concretely as a thing, and the assessment process is often confused with the assessment report. As a result, a few sheets of paper can take on magical symbolic significance and, in being separated from the assessment process, can be used inappropriately in making important decisions for a child.

Summary

Our definition of "assessment" includes the following basic characteristics:

1) It considers both achievements and limitations
2) It requires:

- o the gathering of facts about many areas of functioning both in the past and the present
- o the observation of the person both individually and within his current social network
- o the thoughtful integration of facts, observations and intuitive reactions towards reasonable assumptions
- o the appropriate classification or diagnosis of needs or deficits
- o the development of relevant planning for assistance or treatment
- o the arranging and negotiating of such plans, i.e. brokerage

CHAPTER 3:
A CONCEPTUAL FRAMEWORK FOR ASSESSMENT

This chapter attempts to consider the scope of assessment procedures and the range of information considered necessary for adequate assessment. It will not specify details but rather will discuss principles and attitudes which derive from the best of current thinking and experience.

Each of the major streams within the Children's Services Division has traditionally been charged with responsibility for dealing with children to whom a simplistic label can be attached.

Child welfare services developed to assist children described as:

- deprived
- neglected children
- abused
- orphaned
- abandoned.

Day nurseries have been developed for children who are:

- at risk
- developmentally handicapped
- economically deprived

Mental health services attempt to treat children described as:

- mentally ill
- emotionally disturbed
- behaviourally disturbed.

Probation and corrections services deal with children described as:

- delinquent
- antisocial.

Similarly, mental retardation services clientele have been labelled:

- mentally deficient
- retarded.

Various medical and social services care for children described as:

- crippled
- disabled
- chronically ill.

Traditionally, these gross categories have served an important purpose in identifying populations of children for whom parents or society wished to obtain special and necessary assistance. All of the descriptive labels imply deficit, disorder or disease in the child or in his (or her) immediate environment. The basic task of the various services has been to compensate for deficit, to control disorder, and to heal disease. Each service's efforts at understanding a child more clearly have consequently been shaped and biased by its orientation towards a particular framework of dysfunction so that:

- child welfare services have emphasized
  family and social evaluation

- mental health services have emphasized
  intrapsychic and interpersonal assessment

- probation and corrections services have emphasized
  social and behavioural evaluation

- day nurseries have emphasized
  multi-disciplinary assessment for proof of need for subsidy.

While this last point can be viewed as overly simplistic, it must also be acknowledged that each field of human service has biases and attitudes which can be troublesome and puzzling to the others. This means that useful collaboration between services and professions requires continuous striving for mutual respect and understanding in order to overcome such biases and to integrate the best of each profession's skills and insights.

Increasing awareness of the complexity of human development and the multitude of factors which can influence behaviour has demanded that workers in the various services attempt to achieve a richer, more sophisticated and more individualized understanding of each child. A growing awareness of the significance of early childhood experience, patterns of family interaction, social consequences of school experience, and of the individual child's view of himself within his personal world must be integrated with the behavioural, social and biological factors which may be more easily identified.

This ecological [1] understanding of the child must begin with the child's biological and temperamental endowment, determined prior to and around birth. It then moves outward from him, both in space and in time, to consider his influence upon his environment and his reaction to that environment in a continuing developmental process. By using such an ecological-developmental framework, it is possible to assess the child's outward growth from womb to mother's arms, to family, and into society, while also assessing his achievements in physical, intellectual, emotional and social development.

Such a framework has a major advantage in that it views the individual in the context of normal growth and development, and helps to avoid the simplistic and negative labelling process discussed earlier. Moreover, the framework provides a means of pinpointing both in time and location those factors, events, and elements which facilitate growth and development and whose absence, loss or disruption might result in persisting deficit, disorder or disease. Identification of those vital factors, events and elements, whether they have occurred in the past or are now present, can then lead to appropriate prediction of specific needs, i.e. those elements of assistance which can be expected to promote continued growth and development to compensate for persisting deficits. Therefore, adequate assessment from an ecological-developmental framework must enquire into a wide range of areas over a constantly evolving life history.

Such enquiry should include the following:

- Family Development i.e. an historical survey of the family and its individual members, noting the functions of each and including both strengths and disabilities. Other important qualities to assess are degree of stability, mutual support patterns, ability to facilitate individuality, clarity of generation boundaries, clarity of roles, capacity to share emotional life, and capacity to adjust to changes as the family grows older. Both the current functioning and earlier history can be linked together in order to understand the interrelationships between the individual and the family starting from birth.

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1 Definition: human ecology - "The study of interaction of persons with their environment" (O.E.D.)

- Personal Development. As suggested earlier, this begins even before birth. Biological development, usually in the form of medical history, should be reviewed. Temperamental style and early biological patterns (sleeping, feeding, motility, awareness, emotional responsiveness) are the foundations of personality style. Achievement of milestones in motor capacities, understanding, communication and speech indicate learning capacities. The pattern of mastering the toddler phase of physical and psychological individuation, dependence-independence conflict and bodily self-regulation (e.g., self-care functions) is highly significant, particularly with regard to the relationship to the primary parenting figures. The development of conscience, moral values, and control of impulses prepares the child to move from the family into society.

- Readiness to move out into the wider environment of peers and school and to comfortably adapt to it measure the beginnings of social adjustment. School achievements indicate capacity to learn and work, and contribute to feelings of mastery and self-worth. Friendships, identifications with the family and important adults, hobbies, sports and special interests measure adjustment in the public school years.

- Reaction to the biological forces of pubescence, to bodily change and sexual feelings, is significant in relation to behavioural and emotional changes. Therefore, the timing of breast development, the first menstrual period and the growth spurt in boys should be noted. Changes in relationships with parents and increasing involvement with peers are a major focus of interest and concern during adolescence; preoccupation with the physical and emotional self and with sexual relationships can be intense as the youngster struggles towards consolidation of personal rather than familial identity.

This second process of individuation, from the family rather than from the mother, may bring back the ambivalence and struggle of the toddler phase. School achievements and the ability to undertake chores and employment are important age-appropriate adolescent tasks to be assessed.

For many children it may be necessary to review specialized medical, educational or psychological investigations prompted by particular areas of concern. In all cases, the above-noted areas in family and individual development should be reviewed. This need not require great expertise, but does demand patience, interviewing skill and familiarity with developmental and social patterns of individuals and families.

When areas of obvious difficulty can be identified, it may be appropriate to request specialized consultation or evaluation by such experts as:

- medical specialists in paediatrics, neurology, psychiatry, gynecology, ophthamology, etc.
- psychologists
- speech, hearing, communication specialists
- education specialists.

In advocating the adoption of an ecological-developmental approach, we attempt to move away from narrow, simplistic and restrictive classification of a child. At the same time we create difficulty for the professional responsible for providing assistance, whose involvement has probably been precipitated by a particular kind of deficit, disorder or disease. The professional has been expected traditionally to focus his attention and efforts on particular needs, deficiencies, disease or behaviour. An ecological-developmental approach demands that the whole child and family be considered, while the identified difficulty remains a focus of concern.

We can see that the conflicting pulls of attending to the identified problem and of assessing the child in his personal ecological-developmental framework can run the risk of missing important aspects of the child's development or of losing sight of the difficulty which created a demand for assistance. While a particular kind of behaviour (e.g., running away) may be understood as indicative of intrapsychic and familial difficulties, identification of those difficulties is not in itself sufficient to change the behaviour or to relieve distress. However, a richer understanding of the child should be useful in the development of a plan for assistance which makes the need to run away unnecessary.

Routine Assessment: Is It Really Useful?

Organizations which must undertake a high degree of responsibility for groups of individuals find it necessary to apply routine procedures to all of them. Armed services, corrections systems, hospitals and child welfare services are examples of organizations which must carry out physical examinations and health screenings in the interest of the individual and the institution.

Similarly, universities, schools and employers may demand routine health assessment. At times it can be difficult to discern whether the health assessment is of true value to the individual, since his health needs may already be well attended. Instead, it may actually serve the institutional needs of the organization, e.g., to have healthy soldiers and employees, to avoid infectious disease in prison, hospital or school, to ensure that a case record is complete, to cover responsibility in a legal sense.

Similarly, organizations have tended to extend other forms of routine assessment or screening to their populations, psychological testing being a particularly well-known and often decried example. It is easy for human service organizations with the best of intentions to develop admission procedures which becomes over-inclusive, mechanical, intrusive, demeaning and dehumanizing to individuals. There is a difficult balance for each organization to maintain between its institutional needs and the individual's needs and integrity.

We suggest that standard or routine intake, admission, and assessment procedures be kept to a basic minimum, that is, sufficient to monitor the needs of all individuals. More elaborate, specialized procedures can then be added on the basis of individual needs. As much as possible, procedures (tests, specialized interviews and consultations) should be carried out after thoughtful deliberation, rather than by thoughtless routine.

Summary

This chapter discusses a conceptual approach to understanding the evolution of a child within his or her environment. Its advantages are that it can be applied usefully towards understanding any child and that it maintains a view of the child as a whole rather than in parts. However, it also demands an awareness of the complexity of childhood development and a readiness to explore beyond surface behaviour and obvious problems. Inasmuch as this approach can elicit a good deal of information, it requires appropriate categorization of material so that the process of development, both outward from the individual and onward in time, can be followed logically.

CHAPTER 4:
THE PROCESS OF ASSESSMENT

This chapter is concerned with how assessment can be done. The most obvious temptation is to set out a list of procedures which could be presented as "a complete assessment", "a comprehensive assessment", etc. Not only would this be presumptuous, since there are various ways of carrying out an assessment, but also it would fall into a trap described in the last chapter. It would risk implying that good assessment should be a routine procedure for which there is a formula. One of our major arguments is that each assessment should evolve specifically and idiosyncratically according to the context of the child's situation. If any routine or formula is required it should be part of an internal framework, within the assessor's thinking rather than an external procedure. -

This chapter will attempt to follow the thinking-through of assessment, acknowledging that along the way a wide range of procedures, interviews and data-gathering external activities is necessary to supply relevant information to the internal thinking process. This can be viewed of as a parallel flow between internal and external activity.

In the beginning it is important to think about the aims of the assessment process. The usual desire is for a solution to a puzzling problem. However, practical solutions must be preceded by consideration of the options available, and the process of deriving a plan must involve a thoughtful weighing of the data available.

Therefore the assessment process can be viewed as:

- problem identification
- information gathering
- integration of information
- ranking of possible solutions
- plan of assistance.

In the phase at which thinking and pondering diminish and planning and implementation begin it is particularly appropriate that the process be laid out in written form, and presented and discussed both with the family and the relevant professionals involved. It should be possible to offer a collection of historical data, observations, specialized consultations, and test findings, and to integrate them in a way which leads to consideration of the appropriate choice of assistance.

The following outline presents a format for assessment information. The sections are intended to flow logically from one to another and their meanings are described as briefly as possible. The possible contents of each section are listed on the right. While it is unnecessary to report on every item suggested, it is important to have explored them in order to know and state which are significant for any particular child.

It is assumed that the information-gathering and observation process will be carried out in different ways by different professionals and services in accordance with their skills, preferences, etc. Direct involvement of parents and siblings is important in the later planning phase as well as at the earlier information-gathering phases.

Again it is emphasized that the following is not presented as a procedure which should be followed, but rather it is an attempt to outline the major areas which require consideration while carrying out an assessment.

Outline for Assessment

SECTION	CONTENTS
Identifying Data "This is the child"	Name, age, address, legal status (natural child, adopted, fostered, wardship, etc.), school, grade.
Referral Source "This is how the child was brought for help"	Names of those persons involved in referral process.
Presenting Problems "This is why the child was referred"	A list of the issues of primary concern: usually behavioural observations.
Informants "These are the people contributing to this assessment"	A listing of the contacts with those persons who have been interviewed or have contributed reports. This may include the child, parents, siblings, teachers, special school services, CAS staff, probation officer, hospitals, physicians, police and other agencies.
History of Current Difficulties "This is what has been happening in the child's life recently and has led to this referral"	Description of problems; duration; how were they noticed and for whom they create difficuties; what precipitates them; where; when; what makes them better or worse. How do the child and family explain the causes. What attempts have been made to help. What are everyone's goals.

SECTION	CONTENTS
History of Previous Difficulties "These are the problems which the child or other family members have experienced in the past"	A review of earlier problems of the family or of its members; derived both from interviews and any reports from other services.
Family Development "This is how his family began and how it has evolved"	1) Parent's early life experiences. A brief review, mentioning composition and style of family of origin. Quality of family relationships; management of discipline and conflict; sharing of affection and feelings. Attitudes to school, work, sex, money, the law, school and work achievements. 2) Courtship and marriage. How the couple met and what attracted them. What they expected in the marriage. Significant factors in early adjustment; sexual, social, and economic. 3) Arrival of children. Planning for children. Pregnancies, births, effect of each child's arrival and reactions of parents and siblings. Personalities and achievements of children. Data about adoptions, fostering, placements. 4) Current marital and family functioning. Style of marriage, ability to cope with responsibilities and with developmental changes in children. Sexual relationship, employment, economic factors, living conditions, cultural and ethnic factors, legal issues, antisocial problems. Significant illnesses, deaths, losses, changes, separations, divorce, and their consequences. Relationship to extended family, community, schools, church, courts, police, CAS and other services.

SECTION

CONTENTS

Personal Development

"This is how the child has coped with normal biological, psychological and social tasks from birth to the present"

Data about:

- Pregnancy, delivery, neo-natal period (including mother's reactions).
- Early physical and temperamental style, developmental milestones.
- Establishment of feeding, sleeping, toilet routines.
- Quality of early relationships, bonding and attachment (to whom).
- Potentially damaging experiences both physical (illness and injury) and emotional (stresses and separations).
- Pre-school development and personality in socialization and play patterns.
- Introduction to school; emotional reaction; early proficiency in learning skills.
- School history, including academic progress, behaviour, relationships with teachers and classmates, adult models, friendships, hobbies, interests, sports, chores, job history.
- Age of maturation (first period, breast development, growth spurt) and reaction to it, interest in sexual matters, sexual relationships, sexual identity issues, masturbation, degree of adolescent individuation from family, involvement with peer group.
- Individual relationship to community, agencies, police, development of conscience and morality.

Observations of the Child

"This is (a) what I saw in the child, (b) what I heard from him about himself, his family and other aspects of his life, and (c) how I felt about him and consequently behaved towards him"

Data and inferences drawn from direct examination, with all aspects being compared with developmental norms.

1) Appearance and Relationship to Examiner.
   - Physical appearance, dress, grooming, social manner, posture, gait, tension, mannerisms, voice and manner of speech, facial expressions and eye contact.
   - Examiner's reaction, nature of the relationship formed and the "working alliance".

SECTION

CONTENTS

SECTION

CONTENTS

6) Attitude to Self and Others
   Ability to see self as individual, predominant models and ideals, aspirations, goals, ethical standards, responsibility, self-control, conscience, sense of guilt, self-esteem, feelings of belonging and being loved.
   Major relationships, number and depth, style of relating degree of closeness and trust.

Observations of the Family

"This is what the family is like, how it feels to be among them, how they approach the child's needs, how they view me and other outsiders. This is how they do/do not share concerns and problem solving. Here are their mutual strengths and difficulties. Here is what we were able to achieve together"

1) Structure and Organization
   Power hierarchy, cohesiveness and interdependency, degree of individuality, clarity of generation boundaries, special alliances, closeness, enmeshment, distance, clarity of roles and functions, rigidity or flexibility of system.

2) Communication
   Content, themes, preoccupations, avoidances, quantity, clarity, directness, unspoken rules, non-verbal expression and its congruence with spoken word.

3) Emotional Tone and Expression
   Mood, intensity, variation, openness, concealment, responsiveness.

4) Control and Decision Making
   Leadership style, flexibility, consistency, type and efficacy of reinforcement conflict resolution, co-operation and resistance, attitudes to feedback and help.

5) Developmental Aspects
   Age appropriateness of expectations, roles, etc.
   Management of autonomy and individuation, parental and marital developmental level, intergenerational issues, extended family, dependency, intrusiveness, support.

SECTION

Specialized Observations

"This is how particular experts understand certain aspects of the child, his family and his situation"

Formulation

"This is an attempt to select and synthesize significant factors from the above information in order to develop working hypotheses about the child. It is speculative at times and cannot be regarded as absolute truth but it aims to combine facts, observations and subjective reactions with generally accepted theories and knowledge of biological, psychological, and social development. It should lead us to an understanding of the child's levels of achievement, delay, regression or disorder in the major areas of his functioning"

CONTENTS

Tests, evaluations, reports and earlier assessments, e.g., educational, psychological, medical, legal, child care observations.
Significant items should be emphasized in this section.

Selection and synthesis are the essential operations in formulation. From the mass of data are selected those factors considered as significant in the development of the problems. Then, in a sequential and logical manner a synthesis is attempted which shows the significance of each and the ways in which the factors affect each other. A mere listing of the factors is not a formulation; the connections between them must be shown.

Formulation is a highly subjective process. It represents an opinion of the case and should be able to stand on its own, even apart from the material from which it is derived. It should point the way to appropriate management by identifying areas of delay, deficit, or dysfunction which can be translated into specific needs.

The model for formulation suggested here classifies significant factors in major areas of functioning (biological, familial, social-cultural, psychological) and also in a sequential dimension (predisposing, precipitating, perpetuating, protecting). The grid shown below creates a framework which helps to put significant factors in place and to consider their inter-relationships.

Biological factors should include basic constitutional and temperamental characteristics of a child as well as health and physical development. Familial factors can be fairly easily separated out, as can socio-cultural factors. Psychological factors are those pertaining to the child's individual emotional and cognitive functions.

SECTION

CONTENTS

Predisposing factors are those whose presence, whether early or recent has helped to set the stage for the development of difficulties. Precipitating factors are likely to be those events or changes both within and outside the child which can be linked closely to the difficulties. Perpetuating factors are those which tend to block the resolution of problems, often in a circular way. Protecting factors are particular elements which by their presence have compensated and prevented even greater difficulties. The availability of a nurturing grandparent to compensate for parental inadequacies, or good intelligence and desire to learn are examples.

The application of the grid is useful in all cases and can help to develop clarity in thinking the case through, but only those factors considered significant should be included.

Factors	Biological	Familial	Social-cultural	Psychological
Predisposing				
Precipitating				
Perpetuating				
Protecting				

SECTION

Classification

"These are the categories, labels, and diagnoses by which we briefly describe this child. They are a form of shorthand and do not describe the child fully"

CONTENTS

As stated in chapter 3, traditional forms of classification have tended to be narrow and eventually dehumanizing. They meet the needs of systems rather than of individuals. While categories and diagnoses are useful as brief indicators of aspects of an individual's functioning, they are unable to describe the person sufficiently.

In recent years there has been growing concern with this dilemma, and various attempts have been undertaken to develop richer and less negatively-oriented classification systems, for example:

- the efforts of Hobbs et al, Vanderbilt University Project
- Michael Rutter's Multiaxial Diagnosis
- the American Psychiatric Association's Triaxial Diagnosis
- the Needs Assessment method

There is undoubtedly a need for the development of a common language for classification of children and of service components within the system of services for Children in Ontario With it, a more rational approach to service provision, evaluation and research can be contemplated. The Children's Services Division is examining approaches to the classification problem, particularly with regard to the needs of children with multiple problems.

The following example demonstrates some of the difficulties in classification:

SECTION

CONTENTS

A 14 year old boy, unhappy and rebellious at home, sometimes truant from school, and reluctant to accept that he requires medication to prevent troublesome and embarrassing seizures.

Medical diagnosis - epilepsy and behaviour disorder
School label - epileptic and emotionally disturbed
Probation lable - truant and epileptic

Can there be a system of classification which describes the boy sufficiently and yet also meets the requirements of the various systems which deal with him? Needs assessment is a method which has gained support in the social service field because of its emphasis on goals and needs and its apparent lack of negative connotations. Our 14 year old boy might be described as having the following needs:

1) to prevent seizures
2) to alleviate shame and loss of self-esteem
3) to reduce conflict at home
4) to improve school attendance

These needs can then be considered in choosing appropriate treatment and assistance, e.g.

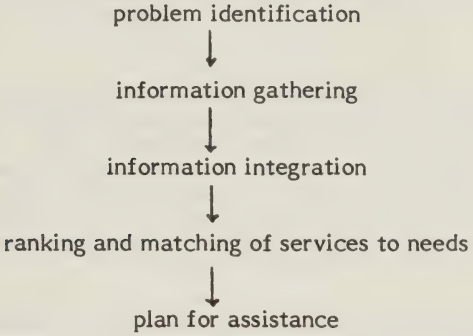
1) medication and medical follow-up
2) individual counselling
3) family counselling
4) supportive understanding by school, to be achieved by consultation with staff

While needs assessment may be cumbersome in describing children, its emphasis on identification of goals appears to be useful in planning for case management.

SECTION	CONTENTS
Planning and Brokerage "These are possible means of helping and how they can be negotiated between the child, the family and service providers"	This part of the assessment process consists both of identifying the kinds of assistance which might be useful to the child and obtaining them by negotiation rather than simply recommending or imposing them without regard to acceptability and availability. It is of questionable value to undertake assessment which does not ensure that some form of help is provided and the assessor need not be discouraged if his first suggestions are not possible. A family which sees no value in psychotherapy may be appropriately helped by the supervision of probation or child welfare services. The youngster who appears to be too difficult for most group homes may benefit from intensive one-to-one child care management while still living at home.
Prognosis "This is an educated guess about the outcome of the plan and the probable course of the child's development"	This requires a predictive statement which speculates about the child's and family's potential for healthy development and functioning, and about the relevance and acceptability of plans for assistance.

Summary

A useful and relevant assessment process for children with special difficulties and needs should provide, in varying degrees of detail, categorized information which can be presented in a logical flow:



The process should be communicable to others in a familiar and recognizable form, such as:

- identifying data
- referral source
- presenting problems
- informants
- history of current difficulties
- history of previous difficulties
- family development
- personal development
- observations of child
- observations of family
- specialized observations
- formulation
- classification of achievements
  - deficits
  - needs
- planning and brokerage for service
- prognosis

CHAPTER 5:
WHO SHOULD BE RESPONSIBLE FOR ASSESSMENTS?

Formalized assessment procedures for children have traditionally been carried out in whole or in part by social workers, teachers, nurses, physicians, psychologists, psychiatrists, probation officers and child care workers. Both by training and experience, the individual professional worker's expertise may be fairly explicitly defined. On the other hand, it may also have extended beyond traditional boundaries to include familiarity with knowledge from other fields.

Our ecological-developmental approach is not seen as the property of any particular discipline. It demands the ability to "think laterally" between various theoretical and professional frameworks, and to integrate them creatively in assessing the strengths and needs of each child. This requires staff whose thinking style is free of rigidity, and who can engage comfortably in dialectical processes which consider people and problems from various points of view and without preconceived ideas.

During the past decade in the social welfare and mental health fields there has been a considerable effort to develop areas of shared or common expertise. Such concepts as generic worker, generalist, and case manager have evolved. These names are clearly attempts to avoid the use of traditional role labels. Case manager is one which can be usefully applied to our concept of assessment. It suggests a degree of personal and professional responsibility for planning and implementation. However, it does not imply anything about assessment and perhaps "assessment manager" would be more specific.

While the assessment manager's profession is likely to be one of those listed above, we would prefer to define the assessment manager by experience and skills rather than by profession; not all professionals have such experience and skills. The following are suggested as requirements for competency in assessment management:

1) experience and training in social service or mental health disciplines

2) understanding of:
   - normal and abnormal development
   - family development and dynamics
   - communication/interaction theories
   - social systems theories.

3) skills in:
   - individual interviewing, including mental status examination
   - family interviewing

- observation and recording of verbal and non-verbal behaviour
- self-observation in interaction with children and families
- awareness of interviewer's effect on children and families
- awareness of personal biases and patterns of reaction in interviews.

4) ability to:

- seek out and use specialized consultations, procedures and reports, e.g., psychological testing, medical consultations, special education consultations and reports
- develop the material into useful working hypotheses by applying both experience and theoretical knowledge
- relate hypotheses to both ideal and accessible services in developing management plans
- negotiate as broker between family, agencies, courts and so on in obtaining services
- present the above material and activities in written and verbal form.

Teams and Teamwork

Earlier in this chapter we advocated the designation of "assessment manager" for the individual who has basic responsibility for the assessment. No matter how skilled and experienced the individual professional is he or she must be complemented by colleagues and consultants who can provide other specialized skills or additional conceptual frameworks which, in total, produce a fuller and more balanced understanding of the individual child. For example, a social worker who is particularly skilled in individual and family interviewing might find the behavioural concepts or the interpretation of testing of a psychologist to be helpful in confirming hypotheses or in raising new questions. The social worker's awareness of say, family dynamics, similarly can be of assistance to the psychologist.

When it works well such pooling of experience can provide an enriched thinking about each child and mutual support among assessment staff. This has been demonstrated in the increasing use of teamwork concepts in the past decade. Not only in human services, but also in business and industry it has been felt that a team approach can strengthen each member and at the same time provide a more egalitarian and less hierarchical structure for authority, responsibility, and quality control.

Within the mental health field, teams originated with very strictly defined roles for members. In the traditional child guidance clinic model the psychiatrist interviews the child, the social worker interviews the parents, and the psychologist tests the child. This has evolved considerably in many places with increasing sharing of skills and functions. It would appear that such a trend is both general, within the mental health field, and also specific in that agencies themselves, if flexibility and creativity is valued, tend to evolve during their existence in ways that permit task-sharing and diminish role-restriction.

Teamwork in children's services has become well established and valued, but at times it appears to be badly used. At this point it is necessary to give consideration to aspects of the teamwork approach.

There is a considerable body of literature (see bibliography) which discusses both the benefits and drawbacks of teamwork. A particularly significant contribution was made by the Group for Advancement in Psychiatry in From Diagnosis to Treatment. Cosgriffe and Dailey in Teamwork in Problem Solving state the following conditions as justifying teamwork:

- when problems require several perspectives
- where several possible solutions are involved
- where group solidarity is needed
- where each person can make a unique contribution
- where the various contributions are coordinated
- when the sum of deliverations and alternatives is greater than the work produced by individuals working independently.

The following have also been identifed as advantages of teamwork in human services:

- the opportunity to share and exchange functions flexibly
- a sharing of responsibility in difficult and painful work
- an egalitarian rather than authoritarian means of reporting, monitoring, etc.

Potential difficulties in teamwork include the following:

- o insufficient contact for a cohesiveness to develop from shared experience
- o personal or professional interests overriding the team's interest
- o hidden power struggles hampering the work goals of the team
- o splitting the assessment into pieces (by specialized assessment roles) with insufficient integration of findings, i.e. the "humpty dumpty problem"
- o avoidance of responsibility for case management and service provision
- o excessive blurring of responsibilities
- o lack of clarity and decision-making responsibility.

Teams can be valuable in assessment work when the positive conditions are present. However, it is easy for groups to develop undefined and covert patterns of work-sharing. It is essential that teams regularly in an open manner examine and redefine their functions.

Inter-Agency Teams

Inter-agency teams which have been developed for specific problems such as child abuse and management of difficult children are burdened with additional tasks since members must also represent the parent organization's interests. Such teams need a good deal of autonomy and internal cohesiveness if they are to be able to bridge the gaps between the various services' orientations. Groups which meet rarely and whose members do not spend a good deal of time in contact with each other probably cannot be accurately described as teams and might better be called committees.

Levels of Assessment and Staff Qualifications

The preceding chapters have offered an approach to the process of assessment which risks appearing both exhaustive and exhausting. The model is not put forth with the expectation that every child requiring help will be studied elaborately. However, it is suggested that the underlying approach is necessary whether the problems seem mild or severe, the problems are few or many, or whether the child is new or familiar to service agencies.

At the initial contact between child or family and service provider (i.e. intake) the process of thinking-through PROBLEM----→INFORMATION GATHERING----→FORMULATION----→SERVICE PLANNING is a necessary sequence, just as it will be when more extensive assessment is carried out. Any differences will be in degree, in the following parameters:

- o time used
- o urgency
- o quantity of information obtained
- o extent of observations.

It is important to recognize that thoughtful intervention at any level includes the development of a provisional formulation. Even at the point of intake the basic facts available shape the working hypotheses which guide subsequent steps. It can be useful at any point in an assessment process to formulate the case with the data available. As more information is obtained, the formulation can change or become more complex in a process of evolution.

While some children and families require only brief contact or crisis intervention, it is necessary to apply to their situations the same thoughtful process as to more elaborate assessments. The crisis, while transient, may be "the tip of the iceberg", and it must be evaluated and understood. Such work should be seen as requring the involvement, whether front-line or back-up, of experienced staff whose informed and intuitive responses are likely to develop plans which are neither insufficient nor excessive. There is a tendency for service organizations to give crisis/emergency responsibility to newer and less-experienced staff. This "throwing them in at the deep end" may promote rapid learning in the area of problem-solving, but it also has risks. A strong case can be made for having initial screening and crisis management handled by staff whose experience can provide the best possible service to children.

Experienced staff are also more likely to be able to discriminate between the levels of assessment/intervention/assistance which are suitable for each situation, a task which requires a sophisticated understanding of the dynamic process which occurs between families and services.

Reassessment

Once an adequate assessment has been carried out, reassessment should be needed only because of the passage of time and the occurrence of new events. The historical and developmental data can usually be carried forward whereas observational material must be fresh and current. When it is possible there is much to be said for maintaining continuity by having the original assessment manager re-evaluate the child and his new circumstances. Far too many children have been subjected to repeated assessment procedures which do not lead to help.

At the same time it must be kept in mind that a small number of families find it extremely difficult to return to a particular agency or worker and need to be allowed a fresh start. This naturally is a matter in which it is necessary to use clinical judgement rather than a fixed policy.

It may useful to consider the value of labelling different levels of assessment, for example:

- o intake assessment
- o crisis/emergency assessment
- o partial assessment (to indicate an assessment which is necessarily or deliberately limited).

However, there is a risk that labels for various types of assessments will skew the process to meet the needs of a system, and diminish the range of options for a child. For example, "pre-placement assessment", "pre-committal assessment" or "pre-wardship assessment" tend to imply that the assessment is a routine step which must be taken in order to achieve an already selected result. It is essential that every assessment or reassessment be viewed as a means for exploring all possible options for assistance. If the assessment's purpose is narrowed by definition or choice, it is likely to be more routine, less flexible and less creative.

Pre-Admission Assessment

When an adequate assessment has been carried out it should not be necessary for a service agency to carry out a prolonged reassessment. "Send us your material and we'll do an assessment" is a familiar statement which creates considerable frustration within the service network. A child and family should not be expected to readily expose themselves to a new agency which is likely to turn them down.

It should be possible for intake staff to judge very quickly whether a child and family are likely to fit the service program. Attendance by the assessment manager at an early intake screening conference can enable the service providers to evaluate the adequacy of the work already done and to decide whether to proceed towards admission or to offer other management suggestions. Direct contact with the child and family should be needed only for contracting purposes after a provisional commitment to provide service has been made.

Summary

This chapter discusses the skills needed for assessment of a child. Breadth and flexibility in thinking across various theoretical approaches is seen as essential. Advantages and difficulities in the use of teamwork are considered.

Levels of assessment are discussed with emphasis on the need to apply a broad and comprehensive approach, even to brief contacts or emergency situations. Formulation is seen as a necessary step at any level of assessment.

Assessment must be viewed as an opportunity to explore all options and not as a means of obtaining an already preferred course of action.

CHAPTER 6:
WHERE SHOULD ASSESSMENT BE DONE?

In recent years there has been a marked tendency to move away from institutionalized assessment, whether residential or non-residential. The use of the term "community-based assessment" in the juvenile corrections system in Ontario indicates recognition of the limitations of routine residential assessment, and a wish to develop assessment processes that are ecologically relevant to each child.

If they are to avoid becoming "sausage factories", assessment facilities must continually strive to comprehend and work within the child's personal and social network. This is important in developing an understanding of a child's situation and crucial in obtaining useful services, management, or treatment. The assessment mill which provides information, observations and diagnosis is of little value if it cannot also take responsibility for ensuring that services are obtained or developed within the child's personal and social network.

Are Assessment Centres Needed?

In non-urban areas and in regions which feel under-serviced, the provision of new assessment centres may reasonably be seen as an answer to current difficulties. However, it appears that limitations on manpower, expertise and funding are likely to restrict the creation of many new resources. Therefore assessment needs may have to be met by developing existing services and by collaborative interagency and community efforts.

The Children's Services Division needs to consider the provision of training and consultation in assessment and case management skills in the various services which it funds. Communities, and their Local Children's Services Committees, face the task of developing relevant assessment services from within their existing networks of health, education, child welfare, probation and corrections, and mental health agencies.

The report of the Task Force on Family Court Clinics published by this Ministry emphasizes the need for interagency co-operation. Much of its framework can be adapted appropriately for the provision of assessment services for children not before the courts. Pioneer interagency projects in several communities (e.g., Hamilton and London) have attempted to cut across boundaries between agencies and ministries. Their experiences can be used as new efforts are made in other communities to develop assessment services.

Residential Assessment

Removing a child from his or her home or community is usually a dramatic, confusing and painful experience. Our increasing understanding of the damaging effects of hospitalization and separation upon children has led to the wish for extreme caution in the placement of children outside their own personal environments.

Assessment of a child in a strange institution may give some understanding of his or her behaviour in that setting, but will probably be grossly inadequate with regard to family relationships or the child's functioning in school and in the community. This dilemma is being addressed by Ontario's training school system in the decentralization of assessment of its wards (from Oakville Reception and Assessment Centre to the regional schools). However, many complex issues hamper the development of community-based assessments.

Placing children for assessment in mental hospitals and children's mental health centres has become subject to more stringent criteria in recent years. It is unlikely that a child can be placed in such a setting now without a thorough assessment having already occurred while he or she was still at home. Obvious exceptions are necessary in the cases where there is danger or suicidal risk.

The growing reluctance of mental health settings, children's aid societies, and family court judges to move children abruptly, combined with an increasing demand for the protection of children's personal rights, can create a sense that there are insufficient facilities for urgent assessment in crises. Family court judges and court-related services can then view the observation/detention home as a potential assessment centre.

While observation/detention home staff should be able to provide behavioural observations of the children in their care and to participate in assessment processes, few if any could be expected to function as assessment case managers by our criteria.

In addition, the use of detention in order to obtain assessment seems questionable. Detention surely should be viewed as an emergency procedure, to be terminated as quickly as possible. Detention-for-assessment can lead to unnecessary restriction of the child in the interests of the assessment service, rather than in his or her own interest.

Summary

This chapter discusses issues related to the location of assessment services:

- o within an agency
- o among community agencies
- o within residential/holding facilities

The arguments are directed towards community-based and shared assessment functions rather than towards centralization and institutionalization of the process within assessment centres.

CHAPTER 7:
SUMMARY OF MAJOR POINTS

The following points have been extracted from the preceding chapters; they are regarded as particularly relevant for discussion:

1) It is essential in each instance of assessment to state with clarity the purpose or purposes which can be identified for the child, the family, the referring persons or agency, and the potential service providers. It is of questionable value to attempt to assess a child's functioning in isolation from the particular concerns of the significant parties involved.

2) It is essential that those persons who are in decision-making positions carry a responsibility for expecting good quality assessment work from those of us who are assessment providers. In their "gatekeeper" positions program directors, family court judges and senior staff in all services must demand that plans and suggestions follow logically from sufficient exploration and understanding of the functioning of the child and family.

3) Some categories and labels are needed in order to know how many children require certain special services, and they can be useful in matching individual children to particular services. However, they can also become misused in covert ways which degrade children, deny their humanity, and hinder appropriate case management.

4) Assessment can be viewed as a basic human process which ranges from the brief and intuitive to the thorough and thoughtful. A competent assessment involves the assessor reflecting upon:

   - his or her personal reaction to the information
   - his or her personal reaction to the assessment process, and the persons involved in it
   - his or her professional knowledge and experience.

5) There is a need for a recognizable form and order to the assessment process by which the assessor can demonstrate a logical flow to the collection of facts, observations and reactions towards the development of reasonable assumptions, appropriate classification or diagnosis, and relevant plans for assisstance.

6) Assessment is described as a process. Unfortunately, it is often confused with the assessment report, a few sheets of paper which can take on an almost magical, symbolic significance.

7) Assessment considers both strengths and weaknesses, achievements and limitations, and requires:

- o the gathering of facts about many areas of functioning both in the past and the present
- o the observation of the person both individually and within his current familial and social network
- o the thoughtful integration of facts, observations, and intuitive reactions towards reasonable assumptions
- o the appropriate classification or diagnosis of needs and deficits
- o the development of relevant planning for assistance or treatment
- o the arranging and negotiating of such plans, i.e. brokerage.

8) The use of an ecological-developmental framework views the individual in the context of normal growth and development, and helps to avoid the simplistic and negative labelling process.

9) Routine admission procedures can become over-inclusive, mechanical, intrusive, demeaning and dehumanizing to individuals. Routine intake, admission or assessment procedures should be kept to a basic minimum; more elaborate, specialized procedures can then be added on the basis of an understanding of the child's individual needs.

10) Though the assessment process will be carried out differently by different professionals, the following format for the communication of the results of the process is suggested:

- o identifying data
- o referral source
- o presenting problems
- o informants
- o history of current difficulties
- o history of previous difficulties
- o family development

- o personal development
- o observations of child
- o observations of family
- o specialized observations
- o formulation
- o classification of achievements, deficits, needs
- o planning and brokerage
- o prognosis.

11) The ecological-developmental approach is not the property of any particular discipline. It demands the ability to "think laterally" between various theoretical and professional frameworks and to integrate them creatively in assessing the strengths and needs of each child. Such a function can be termed "assessment management", which demands a wide range of competence and experience.

12) The use of the team approach can be valuable in assessment work, but it has potential drawbacks which should be considered.

13) While some children and families require only brief contact or crisis intervention, it is necessary to apply to their situations the same thoughtful process as to more elaborate assessments.

14) A strong case can be made for having initial screening and crisis-management handled by staff whose experience can provide the best possible service to children.

15) It is essential that every assessment or reassessment be viewed as a means for exploring all possible options for assistance.

16) Prolonged assessments by residential services should not be necessary in making decisions about admission. Children and families should not be required to expose themselves to a new agency which is likely to turn them down.

17) If they are to avoid becoming "sausage factories" assessment facilities must continually strive to comprehend and work within the child's personal and social network.

18) Communities and their Children's Services Committees face the task of developing relevant assessment services from within their existing networks of health, education, child welfare, probation and corrections, and mental health agencies.

19) The use of detention in order to obtain assessment is clinically questionable. Detention should surely be viewed as an emergency procedure which is terminated as quickly as possible. Detention for assessment can lead to unnecessary restriction of the child for the convenience of the assessment services.

CHAPTER 8:
WHAT COMES NEXT? USES FOR THIS PAPER

This paper has outlined a number of major concerns about availability and quality of clinical assessment of children and families in Ontario. A framework for assessment which is congruent with the philosophy and policies of the Children's Services Division has been described. It does not provide answers to all of the issues in assessment which have been identified within the current service system but is intended to provide a basis for discussion and a starting point for setting standards in assessment work.

To a great extent we have emphasized thoughtfulness and quality and have thus placed expectations upon the service network and the Division. It is likely that the process of assessment described in this paper will be viewed by some as too comprehensive and therefore expensive and time-consuming. Nonetheless, it is our view that improvement in the quality of assessment by being more focused and better understood, leads to more productive use of time and energy.

The following are suggested as ways in which this paper can be used:

1. Within the Children's Services Division:

   - o to provide a starting point for the development of standards in assessment
   - o to assist policy makers and planners in understanding the functions of assessment while they develop models for regional and local service systems.

2. Within the field of children's services:

   - o to guide the development of suitable assessment procedures within services
   - o to serve as a tool for training in assessment in in-service or interagency seminars
   - o to promote integration of concepts and language among the various streams of service provision
   - o to assist in educating interested professionals and lay persons, e.g. Board members, local government representatives and officials, children's services committees, family court judges, lawyers, education officials, public health staff.

As mentioned in the Introduction, a paper outlining a functional analysis of children's services has been developed by the Division and this document should serve as a useful guide to persons planning assessment services at all levels of service delivery.

Development of Assessment Services

The Division is committed to the concept of local community assessment with children remaining, unless for reasons of safety, within their familiar environments. In more sparsely populated areas this clearly presents difficulties but experience with visiting consultants and travelling clinical teams in Ontario has demonstrated that services can be developed. This aspect of service provision provides a particular challenge for creative work and the Division encourages experimentation and variety as new assessment services are developed in communities.

The Division's Task Force on Family Court Clinics (1) has been particularly concerned with the development of local clinical services and one of its major recommendations has been for the formation of a Family Court Clinical Resources Committee. This group will be available for consultation to communities and organizations which wish to develop clinical assessment and treatment services for children and families before the courts and to submit proposals to the Division.

It is the Division's belief that many of the resources needed for good clinical assessment can be developed within the current service system. The limitations on new expenditure demand that the best possible use be made of available services. Rather than attempt to create new assessment organizations the Division is prepared to fund efforts at interagency coordination of assessment, pooling of resources, and training programs, workshops and conferences which will increase assessment skills and capabilities.

Classification and Diagnosis

In Chapter 4 we have stated concern about the difficult issue of classification and diagnosis but have not stated any opinion or conclusions. While no present system of classification or diagnosis can be regarded as satisfactory in children's services it is likely that a system will be needed by the Division. Such a system can have the benefit of providing some commonality of concepts and language among services and facilitating better exchange of information. For the individual child and family the most significant benefit should be better matching of services to the individual and fewer breakdowns and changes in placements and management plans. The Division sees the issue of classification as an important area for debate in the children's services field during the coming year.

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1. Report of Task Force of Family Court Clinics - October/78

APPENDIX A

Case Example for Formulation (see Chapter 4)

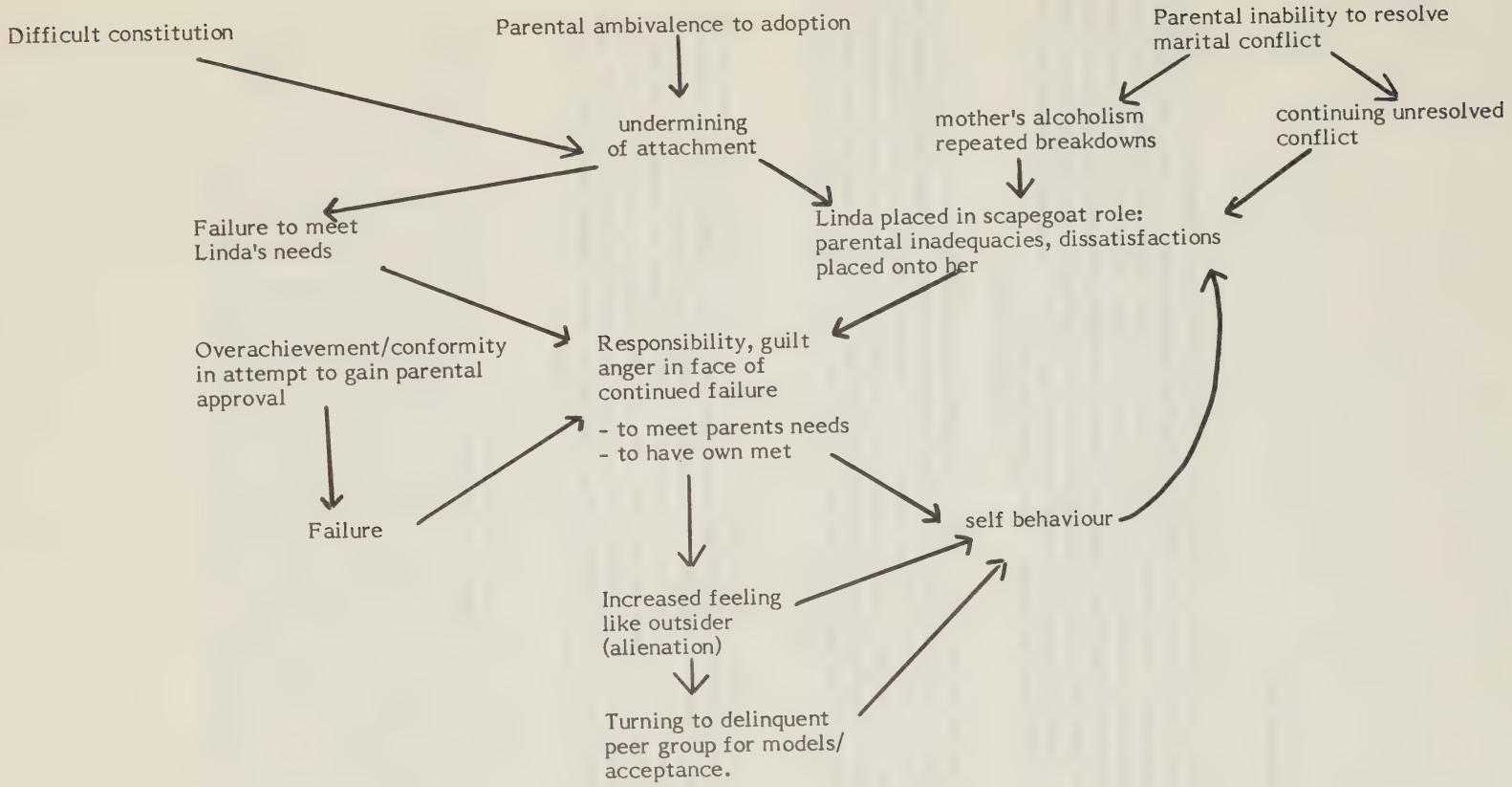
Linda is a 14-year old only child adopted at birth, who has been increasingly rebellious since age eleven. Truancy and running away are major problems and she has been closely involved with an antisocial subculture. Her middle-class parents have had little marital satisfaction, and each has had serious psychiatric difficulties. Father repeatedly fails in his work and is highly critical of his wife and daughter, while mother suffers psychotic depressions and episodes of alcohol abuse. The parents unite to criticize Linda, who contains her feelings but runs away for relief. She was a pleasing child in earlier years and did well in school. She seems bright and articulate and has a fairly positive relationship with her children's aid society worker, although they disagree regarding possible choices of placement.

Relevant factors from history and observations have been inserted in the grid which allows consideration of major areas of endowment, experience and functioning to be laid out and reviewed. The predisposing/precipitating/perpetuating/protecting dimension allows the weighting of significance of factors in ongoing development of strengths, problems and personal style. The final formulation should summarize major factors, atttribute significance to them and show their inter-relationships which are demonstrated in the flow diagram.

FACTORS	BIOLOGICAL	FAMILIAL	ENVIRONMENTAL	PSYCHOLOGICAL
PREDISPOSING	none identified	father's ambivalence about adoption; marital conflict; guilt-ridden and guilt-inducing style in parents; emotional dependency of mother towards child; family burdened by striving to achieve and repeatedly failing	lack of siblings; adult-oriented atmosphere; lack of mother's presence at times in early life because of hospital admissions	maternal illnesses and parental quarrelling producing stress and sense of responsibility in child; compliant, well-organized, skillful, and supportively meeting mother's need
PRECIPITATING	early maturation with differentiation from peers and stressful sexual and assertive drives	mother's depression and drinking creating guilt and attempts to support in child; nagging and criticizing of child by parents	social isolation of family; discomfort in school and with peers; attraction to anti-social young adults and identification with them	pubescence producing more abstract and differentiated thinking and need to individuate from parental style and expectations; identification with substitutes for lost natural parents
PERPETUATING	mature appearance elicits inappropriate expectations from others; impulsive tattoo causes embarrassment and shame	parental need to unite by scapegoating child and to maintain their self-esteem by demanding exemplary and conforming behaviour	sense of support in subculture; continuing stress at home	expects rejection by "normal" peers, projecting hostility into them; relieves stress by running; torn between self-assertion and placating parents
PROTECTING	good physical health; constitutional inheritance from natural parents may be better than that of either adoptive parent	financial support from extended family; positive aspects of work ethic and upward striving	conscientious and consistent care and nurturing in early years; camps, dance lessons etc. provided added skills and competence	good intellect; previously good ability to learn; capacity to form positive relationships

FLOW DIAGRAM

To Illustrate Patterns of Interaction Between Significant Factors



Formulation

Linda is a 14-year old adopted only child who shows rebelliousness and runs away from home and school. Paternal ambivalence at adoption suggests inadequate attachment and a role for the child in personifying the continuous marital discord. Parental inadequacies and dissatisfaction became displaced on Linda with ever-increasing demands for achievement. Her inability to meet parental needs, her mother's repeated illnesses, and the parents' quarrelling each burdened Linda with responsibility and guilt in her early years as strove to be a pleasing child.

Social isolation and a lack of siblings made peer relationships difficult to achieve. Early maturation and her adopted status increased Linda's sense of being an outsider. She relieved this by escaping to an "outsider" subculture in which she may have unconsciously sought her fantasized natural parents. Mother's depression and dysfunction and the hostile criticism of both parents intensified feelings of guilt and alienation which Linda repeatedly tried to escape by running away.

The difficulties are perpetuated by interacting patterns of scapegoating, mutual rejection, and projection of feelings of guilt among family members. Linda's involvement in an antisocial subculture provides an illusion of intimacy and of support based on collusion against external authority. Fortunately, Linda is able to use her intellectual strengths in her own interest and to capitalize upon a degree of trust and warmth which must derive from early nurturing. Her mastery of numerous skills suggests a good capacity for constructive development beyond the current crisis.

It is unlikely that Linda can continue to attempt to live at home because of the intese and destructive patterns which are evident. A prolonged placement may facilitate emotional individualization from her parents and consolidation of her own identity. The placement can be family-like but should tolerate emotional distance between house parents and Linda unitl she seeks intimacy, while non-judgmental firmness is essential for the re-establishment of healthy routines in school, social life and the home. Family therapy should be avoided because of the emotional instability of family members. However, individual therapy for Linda may be a useful adjunct to management. Mother's illness requires psychiatric management and both parents need assistance from their Children's Aid family worker in maintaining positive and non-intrusive relationships with Linda.

APPENDIX B

SELECTED BIBLIOGRAPHY ON ASSESSMENT

APPENDIX B: SELECTED BIBLIOGRAPHY ON ASSESSMENT

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APPENDIX B: BIBLIOGRAPHY ON ASSESSMENT

I Assessment Components/Framework

Besharov, D. J., "Juvenile Justice Advocacy: Practices in a Unique Court" (New York: Practicing Law Institute 1974)

Lists factors used to asses whether a case should proceed to court.

Cosgriffe, Harry A. and Dailey, Richard T., "Teamwork in Problem Solving" in Virginia Griffin, ed. "Program Planning and Adult Education" (Toronto: O.I.S.E. 1969)

The social, physical and institutional environment in which Cooperative Extension Service staff members function is characterized by increasing profusion, variety, and complexity. Consequently, new modes of Extension practices are required. One is discussed in this paper in which prevailing views of teamwork are analyzed, a new definition is stated with guidelines for implementing it, problems of getting commitment are identified, and conditions are described that contribute to team efforts to solve problems.

Committee on Child Psychiatry, "From Diagnosis to Treatment: An Approach to Treatment Planning for the Emotionally Disturbed Child" (New York: Group for the Advancement of Psychiatry 1973)

In this book, planning is seen as a psychosocial process carried out by people, with people, and for people in a cooperative venture. As such, one would expect the progress of the venture to be punctuated by interactional pitfalls and this proved to be the case, as indicated in the text. Like every act of human cooperation, the begetting of trust and confidence was shown to be crucial to the maintenance of continuity in planning.

Cox, G. B., Carmichael, S. S. and Dightman, C., "An Evaluation of a Community Based Diagnostic Program for Juvenile Offenders, Juvenile Justice, 1977 (August) pages 33-41

Describes deficiencies inherent in centralized diagnostic centres (like ORAC); advocates use of community based diagnostic studies for predispositional assessments, using diagnostic co-ordinator, diagnostic committee, peer advocates. Only most serious cases have full assessment. Lists components of predisposition assessment.

Emerson, R. M., "The Juvenile Court: Labelling and Institutional Careers" (Ph.D. dissertation, Brandeis University, 1968)

Traditional model of court clinic assessment.

Fish, L. E., Dire, E. R. and Ehlert, S. S., "Sound Decision Making: A Juvenile Court Mandate", Juvenile Justice, 1977 (Vol. 28) pages 23-27

Probation officers decide which youths penetrate and which should be diverted from the juvenile justice system. Decision usually made subjectively. Paper discusses discovery of a tool which is able to assess environmental variables supporting delinquency with 85% accuracy.

Friedman, R., "An Educational Psychologist in a Psychiatric Clinic". Children, 1967 (Vol. 14) pages 193-196

Describes components of a comprehensive psychoeducational assessment as used in a community psychiatric clinic.

Goldstein, E. H., "A Multidisciplinary Evaluation of Children with Learning Disabilities", Child Psychiatry and Human Development, 1974 (Vol. 5) pages 95-107

Discusses need for multidisciplinary approach for children with learning disabilities. Lists components of a learning difficulty evaluation.

Gorham, K., et al, "The Effects on Parents of the Labelling of their Children", in N. Hobbs, "Issues in the Classification of Children, Volume II (San Francisco: Jossey-Bass Inc. 1974)

Stresses the importance of informing the parents of everything that is done with the child; importance of including parents in the decision-making process about treatment plans.

Hansell, N., "Patient Predicament and Clinical Service: A System", Archives of General Psychiatry, 1967 (Vol. 17) pages 204-210

Describes screening-linking-planning conferences used to identify persons at risk of institutionalization, and identify network of agencies which can be linked to patient's predicament. Use of mental health expediter, responsible for case management.

Hobbs, N., "The Futures of Children" (San Francisco: Jossey-Bass Inc. 1975)

Book describes the ecological model of child assessment. Ecological model belongs to no one discipline but rather someone who can move freely among them, coordinating planning and programming for child, performing liaison function. Book describes steps to be taken by this liaison person in defining the ecological system of the child.

Lewis, D. O., "Evaluation of the Juvenile Offender: Toward the Clarification of Often Overlooked Psychopathology", Child Psychiatry and Human Development, 1976 (Vol. 6) pages 198-213

Advocate meticulous diagnosis of allegedly delinquent children, because when psychosocial factors show obvious deprivation, psychiatri and neurological factors are often overlooked. Lists elements of such an evaluation.

Marholin, D. and Bijou, S. W., "A Behavioural Approach to Assessment of Children's Behavioral Disorders", Child Welfare, 1977 (Vol. 56) pages 93-106

Criticizes traditional assessment methods. Proposes a highly pragmatic behaviourist model, with emphasis on current behaviours. This approach includes only information necessary for treatment planning. Knowledge of child's history often unnecessary. Available psychometric tests provide almost no useful information for treatment planning. Global goals must be operationalized.

Mittler, P., "The Psychological Assessment of Mental and Physical Handicaps" (London: Methuen Publishers 1970)

Describes steps used by psychologists for full assessment. IQ tests seen as only the first step. Need for demystification of psychological terms so that findings can be used. Problem solving strategies may reveal more merely the number of items answered correctly.

Salisin, J., et al "Challenges For Children's Mental Health Services" (McLeam, Va.: Mitre Corporation 1977)

Report aimed at identifying areas of research NIMH might pursue. 50 experts were surveyed. Recommendation: detection strategies should be focused on those conditions for which we have both the knowledge and resources to provide effective intervention. Sometimes destructive forces are irreversible. Notes efforts in this area might be useful.

Thompson, R., et al "A Model Interdisci;inary Diagnostic and Treatment Nursery" Child Psychiatry and Human Development, 1976 (Vol. 6) pages 224-232

Description of a diagnostic and treatment program for developmentally disabled children using the multidisciplinary team. Children seen in clinical-educational nursery. Process of assessment is described. Problem oriented methods used. Initial team meeting decides which specialist should assess the child. Final team meeting integrates info and formulates treatment plan.

II Interagency Cooperation and Coordination

Bartlett, D. P. and Schlesinger, S. E., "Toward An Enlightened Consumer: Professional Accountability in Behavioural Assessment" in G. P. Koocher, "Children's Rights and the Mental Health Professions" (New York: John Wiley & Sons 1976)

Problems for professionals in assessing children - services may be too expensive; servces may not be linked to allow for coordinated team approach; fragmentation of servces; professional view themselves as either assessors or treatment people. Assessor should seek services for child.

LEAA'S Office of Juvenile Justice and Delinquency Prevention, "Cost and Service Impacts of Deinstitutionalization of Status Offenders in Ten States". Juvenile Justice Digest 1978 (Vol. 6)

Brief note by consulting firm, into fragmentation of youth services delivery systems. Need for improved evaluation and screening resources to ensure adequate diagnosis and placement; better coordination among programmes to avoid duplication.

Rubenstein, J. A. and Levin, S., "A Model for Interagency Cooperation in the Provision of Mental Health Services for Youths" Hospital and Community Psychiatry, 1976 (Vol. 27

Description of Child and Family Centre which, when establishing two new services for emotionally disturbed preadolescents, strove to involve community agencies which use and provide treatment services. Representatives of these agencies meet as a team (AATD) and are responsible for all clinical decision making. Also uses a specialized program of living in when necessary.

Salisin, J., "Challenges for Children's Mental Health Services" (McLean, Va.: Mitre Corporation 1977)

Report aimed at identifying areas of research NIMH might best pursue. 50 experts surveyed. Lists recommendations. Inadequate communications between agencies, between teachers and mental health professionals. Record transfers ineffective. Poorly coordinated services, etc.

Sonis, M. and Bracken;, C., "Comprehensive Diagnosis and Disposition: A Pilto Programme". American Journal of Orthopsychiatry 1964 (Vol. 34) pages 730-740

Points out that each authority (court, school, psychiatry, etc.) tends to interpret the child's problems in terms of its own functions. Problems dealt with in professional isolation. Paper describes diagnostic and evaluation centres set-up on regional basis, which use multidisciplinary team approach.

Hobbs, N., "The Futures of Children" (San Francisco: Jossey-Bass Inc. 1975)

Points out in some detail the problems of fragmentation of services, and the way in which defining the condition of a child by an authority leads to institutional arrangements that confirm the validity of the definition.

III Court-Related Assessment

Arthur, L.G., and Gauger, W.A., "Disposition Hearings: The Heartbeat of the Juvenile Court", (Nevada: National Council of Juvenile Judges 1974)

Discusses the components of a court report in which the needs, strengths and weaknesses of child are woven into a treatment plan. Treatment plan should be "sales pitch" recommendations to court. Lists components in the judge's dispositional decision.

Besharov, D. J., "Juvenile Justice Advocacy: Practice in A Unique Court" (New York: Practicing Law Institute 1974)

Lists factors used to assess dynamics of an individual's personality. An important consideration in deciding whether a case should proceed to court.

Cairns, B. C., "Social Background Investigations For The Children's Court" Australia and New Zealand Journal of Criminology, 1976 (Vol. 9) pages 109-122

Describes the child welfare officer's report which, under Tasmanian law, is required by a court before disposition of a vase. Components of the report are discussed. Specialists are used as required by the child welfare officer. There should be info in report for court to make "necessary assessment".

Cammarat, F.A. and Stott, M.W.R., "Judicial Administration of Mental Health Services For Juvenile Offenders", Juvenile Justice, 1977 (November) pages 3-7.

Advocates family court clinics as specialized services. Community agency personnel are unfamiliar with juvenile justice system. Describes a particular court clinic.

Celdic, "One Million Children: A National Study of Canadian Children with Emotional and Learning Disorders" (Ottawa: Commission on Emotional and Learning Disorders in Children 1970)

During predispositional assessments, child should be returned home. Court clinic personel should be employed by court. Consultations have limited knowledge of appropriate resources for juveniles.

Cox, G.B., Carmicheal, S.J. and Dightman, C., "An Evaluation of A Community Program for Juvenile Offenders" Juvenile Justice 1977 (August) pages 33-41

Criticizes use of centralized diagnostic centres (like ORAC). Advocates use of community based assessments (predisposition). Lists components of assessments. Structure includes use of: diagnostic coordinator, diagnostic committee, peer advocates.

Emerson, R. M., "The Juvenile Court: Labelling And Institutional Careers" (Ph.D. Dissertation, Brandeis University 1968)

Traditional model of court clinic service. Diagnosis is made in terms of questions posed by court. Probation office maintains control on youth while psychiatrist develops open relationship.

Feldberg, M., "Psychiatric Consultation In The Juvenile Court" Juvenile Court Journal, 1969 (Vol. 20) pages 130-133

Author is child psychiatrist who chairs meeting with probation officers screening for cases which need psychiatric assessment. Author set about training probation officer to pick-up info that is relevant and useful. Psychiatrist's also have to deal with court's level of sophistication. They should be flexible in their functioning and be prepared to accept the fact that the court may not always go along with their recommendations.

Fish, L. E. and Dire, E. R. and Ehlert, S. S., "Sound Decision Making: A Juvenile Court Mandate", Juvenile Justice, 1977 (Vol. 28) pages 23-27

Probation officers decide which youths penetrate and which should be diverted from juvenile justice system. Decision usually made subjectively. Paper discusses discovery of a tool which is able to assess environmental variables supporting delinquency with 85% accuracy.

Hansell, N., "Patient Predicament And Clinical Service: A System" Archives of General Psychiatry, 1967 (Vol. 17) pages 204-210

Describes operation of service unit which uses screening-linking-planning conferences. Courts no longer request commitment for disturbed people, but rather sends them for a screening-linking-planning conference, in which persons in need of institutionalization are identified, and in which the person is linked to a network of agencies.

Huff, F. W. and Porter, H., "Mental Health Consultation In Juvenile Court" Juvenile Justice, 1972 (November), pages 32-36

Discusses needs in juvenile court for mental health evaluation. Some screening mechanism is needed for referral to mental health consultants. A good family/social history by probation officers should help discriminate out youth with problems.

Lewis, D. O., "Diagnostic Evaluation Of The Juvenile Offender: Toward The Clarification Of Often Overlooked Psychopathology" Child Psychiatry and Human Development, 1976 (Vol. 6), pages 198-213

Advocates meticulous diagnoses of allegedly delinquent children, because when psychosocial factors show obvious deficiencies, psychiatric and neurological factors are overlooked. Lists elements of such an evaluation. If accurate label is not given child, child will come to be labelled sociopathic.

Love, C. W. and Bachara, G. H., "A Diagnostic Team Approach For Juvenile Delinquents With Learning Disabilities" Juvenile Justice, 1975 (Vol. 26) pages 27-30

Describes a model for diagnosis and evaluation through the use of a team made up of a psychologist, three MSW's, a resource officer (responsible for placement), and ten probation officers. Team assists juvenile court and attempts to identify learning disabilities within youth.

Nelson, R. O., "The Clinical Psychologist In Juvenile Court" Juvenile Justice 1972 (November) pages 26-31

Describes increasing role of psychologists in juvenile courts who supplements the probation officer's social report with an evaluation reflecting internal psychological states of the youth. Paper lists guidelines for a thorough diagnostic workup and also criteria questions for court to refer child for psychiatric evaluation.

Proskauer, S. and Rolland, R. S., "Youth Who Use Drugs: Psychodynamic Diagnosis And Treatment Planning" Journal of the American Academy of Child Psychiatry, 1973 (Vol. 12) pages 32-47

Describes psychodynamic categories of drug users as used by a court clinic: (a) experimental drug users; (b) depressive drug users; (c) characterological drug users.

Stephenson, P. S., et. al., "The Psychiatric Status And Treatment Needs Of A Random Sample Of Juveniles Charged With Delinquency", Psychiatra Clinica 1973 (Vol. 6) pages 257-270

Study of a random sample of all juveniles charged with delinquency suggested separation of youths into three groups: normal (46%), social delinquent (22%), and emotionally distrubed (32%). The treatment needs of each of these groups is discussed. Authors suggest findings may reflect lack of community psychiatric facilities; juvenile court is the end of the road.

Seymour, J. A., "Children's Boards In New Zealand: Some Unanswered Questions" Australia and New Zealand Journal of Criminology, 1977 (Vol. 10) pages 233-243

Describes a screening process for the court to identify cases which can be dealt with informally. Children's Boards are made of member of: police dept., Dept. of Social Welfare, state services and a local resident. Seen as avenues to other services.

Seymour, J. A., "Children's Boards In New Zealand: Some Unanswered Questions" Australia and New Zealand Journal of Criminology, 1977 (Vol. 10) pages 233-243

Describes a screening process for the court to identify cases which can be dealt with informally. Children's Boards are made of member of: police dept., Dept. of Social Welfare, state services and a local resident. Seen as avenues to other services.

Traitel, R. B., "Dispositional Alternatives In Juvenile Justice: A Goal Oriented Approach" (Reno, Nevada: National Council of Juvenile Court Judges 1974)

Dispositional decisions in juvenile court imply but do not delineate clear goals in the treatment of youth. This book sets out to assist the judge in recognizing major case constellations and making realistic and specified goals for the youth.

IV Team Assessments

Beloff, J. S. and Willett, M., "Yale Studies In Family Health Care" Journal of the American Medical Association, 1968 (Vol. 205) pages 663-669

Advocates use of medical team work, a bridge between patient needs and fragmented resources. Team leadership varies with nature of problem and competence of staff members.

Bowan, W., et al, "The Psychiatric Team: Myth And Mystique". American Journal of Psychiatry, 1965 (Vol. 122) pages 687-690

Discusses need to limit team membership. Team leadership has come to be equated with medical/legal responsibility for patient. Fully democratic team is also questionable. Alternative model for teamwork is also proposed.

Crawshaw, R. and Key, W., "Psychiatric Teams". Archives of General Psychiatry, 1961 (Vol. 5) pages 397-405

Psychiatric is currently regarded as "war-cry for the disorganized". Discusses structure of teams. Optimal size 8. Leader has to balance abrogating and usurping authority.

Goldberg, F. H., et al, "A Conceptual Approach And Guide To Formulating Goals In Child Guidance Teams". American Journal of Orthopsychiatry, 1966 (Vol. 36) pages 125-133

Discusses need for evaluating instrument in child guidance teams which could help organize thinking about goals. Treatment goals seen as flexible guideposts for team.

Goldstein, E. H., "A Multidisciplinary Evaluation Of Children With Learning Disabilities". Child Psychiatry and Human Development, 1974 (Vol. 5) pages 95-107

Children with learning disabilities require multidisciplinary approach. Necessary that members of disciplines not only communicate with each other, but also have working knowledge of what each discipline can and cannot do. Lists components of a L.D. assessment.

Gorham, K., et al, "The Effects On Parents Of The Labelling Of Their Children" in N. Hobbs, editor, Issues In The Classification Of Children Volume II (San Francisco: Jossey-Bass & Sons 1974)

Following initial diagnosis, child is seen by various specialists each with a single-minded perspective; service system is fragmented; no total management plan. A multidisciplinary team evaluation is able to overcome such fragmentation. However, parents must be included in process of decision-making.

Hetznecker, W. and Forman, M. A., "On Behalf of Children" (New York: Grune & Stratton Pub. 1974)

Criticizes use of psychiatrist, social worker and psychologist in their usual roles (inefficient, protracted data and wool gathering approach). It is proposed that families be assigned to one member of child guidance team who is responsible for diagnosis, planning and treatment delivery. Use of other disciplines as required. Advocates blurring of disciplines.

Joint Commission on the Mental Health of Children. "Crisis In Child Mental Health: Challenge for the Seventies". (New York: Harper & Row Publishers 1969)

Recommends early developmental and educational assessment of child's needs should be made by team specialists, considered important for the placement of the disturbed child. The assessment service should follow recommendations and referrals, and should make periodic re-evaluations of adequacy of community treatment and educational resources.

Knoff, W. F., et al. "Social Structure And Verbal Participation In The Psychiatric Case Conference" in P. H. Hoch and J. Zubin, "Psychopathology of Communication" (New York: Grune & Stratton Publishers 1958)

Study found that those participants of case conference with the most training, experience and professional status tended to dominate case discussions.

Kramer, R. M., "Dynamics Of The Teamwork In The Agency, Community and Neighbourhood" in B. Compton and B. Galaway, "Social Work Processes" (Homewood, Illinois: The Dorsey Press 1975)

Discusses compartmentalization of services which are often agency-centred rather than community-centred. Regarded as "everyone's business", teamwork frequently becomes nobody's business. Paper lists six major obstacles to effective teamwork.

Livingston, J., et al. "Comprehensive Child Psychiatry Through A Team Approach". Children, 1969 (Vol. 16) pages 181-186

Describes obstacles to effective teamwork, which results in fragmentation of services: conflict among disciplines, professional identity, separate experiences of each professional with patient. Paper describes a brief assessment by whole team, though further involvement is possible. Child psychiatrist acts as case manager, synthesizing data. Use of specialists according to type of problem; flexible.

Love, C. W. and Bachara, G. H., "A Diagnostic Approach For Juvenile Delinquents With Learning Disabilities". Juvenile Justice, 1975 (Vol. 26) pages 27-30

Describes a model for diagnosis and evaluation to assist juvenile court, through a team made up of a psychologist, three MSW's, a resource officer and ten probation officers.

Modlin, H. C. and Faris, M., "Group Adaptation And Integration In Psychiatric Team Practice". Psychiatry, 1956 (Vol. 19) pages 97-103

Discusses process of team evaluation from cooperative group to integrated team. The integrated team perceives the total organism that is the patient while the discretely faceted team tends to see the patient sectionally.

Modlin, H. C., Gardner, R. and Faris, M., "Implications Of A Therapeutic Process In Evaluations By Psychiatric Teams". American Journal of Orthopsychiatry, 1958 (Vol. 28) pages 647-655

Outpatient psychiatric evaluations must adhere to the following principles: (a) Mental illness is a function of the whole person interacting with his environment, (b) Evaluation should be performed by an integrated clinical team, and (c) Evaluations activate not only diagnostic but therapeutic processes. Change in the patient begins in the course of the assessment. Family involvement is crucial. Team flexibility is essential in effecting temporary incorporation of the family group.

Sonis, M. and Bracken, C. "Comprehensive Diagnosis And Disposition: A Pilot Programme". American Journal of Orthopsychiatry, 1964 (Vol. 34) pages 730-740

Points that each authority tends to interpret the child's problems in terms of its own function. Problems dealt with in professional isolation. Paper describes regional state diagnostic and evaluation centres which use multidisciplinary approach.

Stoeffler, V. R., et al. "Lessons To Be Learned From New Child Health Programs: Where Do We Go From Here?" American Journal of Public Health, 1972 (Vol. 62) pages 1444-1447

Paper describes organizational patterns developed in child health programs which show promise. Important to use multidisciplinary team and allied health professionals from community. Need for skillful referral from one staff to another. Mutual understanding of roles of each team member. There must be an agreed-upon plan of management which spells out objectives of care and timetable.

Thompson, R., et al. "A Model Interdisciplinary Diagnostic And Treatment Nursery". Child Psychiatry and Human Development, 1976 (Vol. 6) pages 224-232

Describes diagnostic and treatment program for developmentally disabled children using multidiciplinary team. Children seen in clinical-educational nursery. Nursery population was six long-term treatment cases and four diagnostic cases. Parental participation was required. Process of assessment is described.

Weissman, H. N., "The Mental Health Team As A Differential Decision-Maker For Child Patients: A National Survey". Psychological Reports, 1975 (Vol. 37) pages 643-650

Study found members of the mental health team strongly agree about the differential relevance of specific criteria for deciding to place clients in, or terminate treatment in (a) individual therapy, (b) group therapy and, (c) conjoint family therapy.

V Assessment in Child Welfare

Kavaler, F. and Swire, M. R., "Health Services For Foster Children: An Evaluation Of Agency Programs", Child Welfare, 1974 (Vol. 53) pages 147-157

Two organizational models for delivery of health services to foster children were identified in N.Y.C. (a) centralization, ensuring control over quality, and (b) decentralization, using local practitioners to integrate locus of child's care with foster family.

Moss, S. Z., "Integration Of The Family Into The Child Placement Process", Children, 1968 (November) pages 219-224

Goal of child welfare is to keep children in their own home. When this is not possible, it is imperative that family be involved in placement decision. Describes principles of family-centred casework, and process of family evaluation.

Roth, F. "A Practice Regimen For Diagnosis And Treatment Of Child Abuse", Child Welfare, 1975 (Vol. 54) pages 268-273

Describes a simplified system of how to identify child abuse. Three types of abuse are identified, and types of treatment suggested. Describes characteristics of parents.

Shah, C. P., "Health Services In Child Welfare Agencies: An Integrated Approach", Canadian Journal of Public Health, 1974 (Vol. 65) pages 34-36

Points to the fact that because many handicapped children are admitted to care out of crisis situations because alternative resources are unavailable, medical and psychiatric services are frequently duplicated, inefficient and fragmentary. Paper describes a better organized service in Vancouver where patients are referred to specialists as required.

Shah, C. P., "Assessing Needs And Board Rates For Handicapped Children In Foster Family Care", Child Welfare, 1971 (Vol. 50) pages 588-592

Describes the need for objective criteria to classify and rate care needed by handicapped children in foster care. A model is described.

Shah, C. P. and Poulos, S. "Assessing Needs And Board Rates For Handicapped Children In Foster Family Care: Progress Report", Child Welfare, 1974 (Vol. 53) pages 31-38

Progress report on use of model described above. A statistical reliability study shows scales developed would be useful for determining foster home board rates.

Shah, C. P. and Kline, C. L., "Children In Child Welfare Agencies: A Model For More Effective Delivery Of Medcal And Psychiatric Services", Canadian Journal of Public Health, 1972 (Vol. 63) pages 517-522

Points out that children with multiple health problems receive fragmented health care; lack of transfer of medical information; changes in foster home; duplication of services; lack of data integration. Authors propose a delivery service system organized on a regional instead of an agency basis.

VI Assessment of Learning Disabilities

Commission on Emotional and Learning Disorders in Children. "One Million Children: A National Study of Canadian Children with Emotional and Learning Disorders" (Ottawa: C.E.L.D.I.C. 1970)

Children with learning disabilities should be maintained in regular services. Specialists must be available for consultation with teachers. Educational assessments facilities should be developed within the school system itself. Teacher involvement in diagnoses essential.

Friedman, R., "An Educational Psychologist In A Psychiatric Clinic", Children, 1967 (Vol. 14) pages 193-196

Describes establishment of a community psychoeducational program within a psychiatric clinic. The psychoeducational consultant adds to the clinical team, knowledge of learning disorders and problems of school adjustments. Lists components of educational assessment.

Goldstein, E. H., "A Multidisciplinary Evaluation Of Children With Learning Disabilities", Child Psychiatry and Human Development, 1974 (Vol. 5) pages 95-107

Discusses need for multidisciplinary approach to children with learning disabilities since they can present wide-range of clinical signs. Paper lists components of a learning difficulty assessment.

Love, C. W. and Bacchara, G. H., "A Diagnostic Team Approach For Juvenile Delinquents With Learning Disabilities", Juvenile Justice, 1975 (Vol. 26) pages 27-30

Describes a model for diagnosis through use of a team composed of a psychologist, three MSW's, a resource officer (responsible for placement), and ten probation officers. Team assists juvenile court and attempts to identify learning disabilities if there is a discrepancy between previous school performance and an achievement test.

Fine, S., "Assessment And Treatment Of The Preschool Child With Maladaptive Behaviour In A Hospital Nursery School: Description Of A Successful Program". Clinical Pediatrics, 1973 (Vol. 12) pages 240-243

Description of a program in which children with maladaptive behaviour were assessed among "normal" children in a hospital nursery school. Teachers meet with specialists regularly. Community nursery teachers also assess whether child is suitable for their schools.

Ozer, M. N. and Dworkin, N. E., "The Assessment Of Children With Learning Problems: An In-Service Teacher Training Program". Journal of Learning Disabilities, 1974 (Vol. 7) pages 539-544

Description of consultative program designed to increase chances of keeping child in regular classes. Teacher who refers child indentifies the strategies she uses to help the child. Then she watches as a consultant uses these and other strategies to help the child succeed in the task.

VII Early Childhood Screening

Maluccio, A. N., "Residential Treatment Of Disturbed Children: A Study of Service Delivery", Child Welfare, 1974 (Vol. 53) pages 225-235

Discusses fragmentation of services in residential treatment of emotionally disturbed children, and need for early detection and better preventive services. Study found that placement occurred three or more years after child's problem first recognized.

Flapan, D. and Neubauer, P. B., "Issues In Assessing Development", Journal of the American Academy of Child Psychiatry, 1970 (Vol. 9) pages 669-687

Paper outlines issues involved in early assessment of development. Discusses models of what healthy development might be. Authors sugges health is capacity to maintain development. Thus what is seen in the child at one time might not be pathologized in the long-term course of his/her development. Authors stress that health of child can only be evaluated over a period of time.

VIII Residence-based Assessment

Maluccio, A. N., "Residential Treatment of Disturbed Children: A Study of Service Delivery", Child Welfare, 1974 (Vol. 53) pages 225-235

Rubenstein, J. S. and Levin, S., "A model For Interagency Co-operation In The Provision Of Mental Health Services To Youth", Hospital and Community Psychiatry, 1976 (Vol. 27) pages 404-406

Description of a Child and Family Centre, which, when establishing two new services for emotionally disturbed preadolescents, strove to involve community agencies which use and provide treatment services. A team (AATD) made up of representatives of these agencies are responsible for all clinical decision-making and can, if felt appropriate, refer child to a "cottage assessment unit". This unit provides detailed evaluation of child; living-in period usually lasts four weeks.

Dahms, W. R., "A Task-Centred Approach To Treatment Planning", Child Care Quarterly, 1977, pages 196-203

Describes a model for treatment planning developed at residential treatment centre for behaviourally disordered, delinquent youth, and past problems in this area. Plans should be intelligible to boys, staff, parents and referral agency staff. They should have relevance and utility, specify clear goals, methods of goal attainment, and criteria to assess goal achievement. Treatment plan format is described. Useful for referral agency personnel.

Kubany, E. S. and Sloggett, B. B., "A Behaviour Therapy Approach to Office Diagnosis and Treatment of Children", Professional Psychology, 1976 (Vol. 7) pages 525-532

Advocates use of office diagnosis within a behaviourist framework. Object of diagnosis is to identify stimuli that elicits maladaptive emotional responses and also the child's behaviour patterns in obtaining what he wants. Test conditions are made to resemble environment in which child is having difficulty. Examiners alter their social behaviour towards child, etc.

Discusses fragmentation of services and failure to follow through individualized treatment plans in residential treatment of emotionally disturbed children. Insufficient interagency cooperation. Poor service delivery. Need for early detection and better preventative services.

Rubenstein, J. S. and Levin, S., "A model For Interagency Co-operation In The Provision Of Mental Health Services To Youth", Hospital and Community Psychiatry, 1976 (Vol. 27) pages 404-406

Description of a Child and Family Centre, which, when establishing two new services for emotionally disturbed preadolescents, strove to involve community agencies which use and provide treatment services. A team (AATD) made up of representatives of these agencies are responsible for all clinical decision-making and can, if felt appropriate, refer child to a "cottage assessment unit". This unit provides detailed evaluation of child; living-in period usually lasts four weeks.

IX Community Based Assessment

Adler, J., "Diagnostic Considerations in Community Planning for Residential Treatment". American Journal of Orthopsychiatry, 1967 (Vol. 37) pages 344-345

Short article on process of differential diagnosis in relation to community planning for residential treatment by a community based intake and planning agency. Team diagnosis determines residential program. Diagnostic differentiation in 3 areas described.

Cox, G. B., Carmichael, S. J. and Dightman, C., "An Evaluation of a Community Based Diagnostic Program for Juvenile Offenders", Juvenile Justice, 1977 (August) pages 33-41

Criticizes centralized diagnostic centres. Advocates use of community-based assessments for the most serious cases before coming to juvenile court.

Davidson, P. O., et al, "Diagnostic Services for Maladjusted Rural Children", Journal of Psychology, 1968 pages 237-243

In supplying diagnostic services to rural areas, clinics may (1) require clinets to come to urban child guidance centres, (2) set up satellite clinics in larger rural communities or, (3) travel to the clients as required. Study found that the most effective service was urban child clinic.

Fine, S., "Assessment and Treatment of the Pre-school Child with Maladaptive Bahaviour in a Hospital Nursery School - Description of a Successful Program", Clinical Pediatrics, 1973 (Vol. 12) pages 240-243

Description of program in which children with maladaptive behaviour were assessed in the hospital nursery school which is primarily composed of "normal" children. Teachers meet with specialists. Community nursery school teachers also assess whether child is suitable for their school.

Friedman, R., "An Educational Psychologist in a Psychiatric Clinic". Children, 1967 (Vol. 14) pages 193-196

Describes establishment of psychoeducational program within a community psychiatric clinic. Lists components of psychoeducational assessment.

Hansell, N., "Patient Predicament and Clinical Service: A System", Archives of General Psychiatry, 1967 (Vol. 17) pages 204-210

Describes operation of Winnebago-Boone Catchment Area Service Unit's use of service-linking-planning conferences which have the effect of linking a system of community agencies to a person.

Rubenstein, J. S. and Levin, S., "A Model for Interagency Cooperation in the Provision of Mental Health Services for Youths", Hospital and Community Psychiatry, 1976 (Vol. 27) pages 404-406

Description of Child and Family Centre whihc, when establishing two new services for emotionally disturbed preadolescents, strove to involve community agencies which use and provide treatment services. Representatives of these services meet as a team (AATD) and are responsible for all treatment decisions. kAlso use of specialized living in program of assessment when necessary.

Rieger, N. I. and Devries, A. G., "The Child Mental Healh Specialist: A New Profession", American Journal of Orthopsychiatry, 1974 (Vol. 44) pages 150-158

Discusses importance of training a new professional capable of dealing specifically with children, child care, education and clinical management. These specialized personnel are needed to treat emotionally disturbed and delinquent children outside of large institutions. Allows for child to be treated in his own neighbourhood.

Seymour, J. A., "Children's Boards in New Zealand: Some Unanswered Questions", Australian and New Zealand Journal of Criminology, 1977 (Vol. 10) pages 233-243

Describes a community screening process to assist the court by identifying cases that can be dealt with informally. Boards composed of member of: police dept., Dept. of Social Welfare, State Services (Indian Affairs) and a local resident. Agency refers to other sources.

Wallace, H. M., "Some Thoughts of Planning Health Care for Children and Youth", Children, 1971 (Vol. 18) pages 95-100

Extending coverage to children requiring comprehensive child services requires the removal of restrictions based on geographic boundaries within a community. Need for better tie-in between physicians in private practice and community services. All physicians serving children need hospital affiliation. Medical service should be linked to community resources.

X Case Management/Record Keeping

Bonkowsky, M. L., "Adapting the POMR to Community Child Health Care", Nursing Outlook, 1972 (Vol. 20) pages 515-518

Describes the problem-oriented method of record keeping as used by the nurse.

Dahms, W. R., "A Task-Centred Approach to Treatment Planning", Child Care Quarterly, 1977, pages 196-203

Describes a model for treatment planning, and past problems in area. Plans should be written in language intelligible to clients, staff, parents and referral agency personnel. They should have relevance and utility, specify clear goals, methods of attainment and criteria to assess goal achievement. Treatment plan format is described.

Goldberg, F. H., et al. "A Conceptual Approach and Guide to Formulating Goals in Child Guidance Teams", American Jounal of Orthopsychiatry, 1966 (Vol. 36) pages 125-133

Description of evaluative instrument which helps organize thinking about goals. Treatment goals seen as flexible guideposts. Diagnosis and goal-setting are inseparable.

Hansell, N., "Patient Predicament and Clinical Service: A System", Archives of General Psychiatry, 1967 (Vol. 17) pages 204-210

Describes screening-planning-linking conferences used to identify persons at risk of institutionalization, and identify network of agencies which can be linked to patient's predicament. Use of mental health expediter, responsible for case management, who links a system to a person.

Hetznecker, W. and Forman, M. A., "On Behalf of Children" (New York: Grune and Stratton Pubn. 1974)

Criticizes traditional use of psychiatrist, social worker and psychologist; protracted wool gathering. Families become confused as to what is being done by whom. Advocates use of case manager drawn from any discipline, who is responsible for diagnosis, planning and treatment delivery. Other specialists called upon as required. Blurring of disciplines is needed.

Hobbs, N., "The Futures of Children" (San Francisco: Jossey-Bass Inc. 1975)

Describes efficient computer method of recordkeeping. A child would have as many descriptors as are necessary to provide the appropriate services. Target dates for specific goals and progress periodically checked.

Jones, H. G., "Principles of Psychological Assessment" in P. Mittler, "The Psychological Assessment of Mental and Physical Handicaps" (London: Methuen Pub. 1970)

The psychologist's report should be intelligible to those involved in actions which follow. The report must be comprehensive and comprehensible to a variety of readers. Even psychologists have trouble understanding the jargon of other psychologists.

Mittler, P., "The Psychological Assessment of Mental and Physical Handicaps" (London: Methuen Publishers 1970)

Describes steps used by psychologist for full assessment of children. IQ only first step. Need for demystification of psychological terms so that findings can be used. Written reports must be intelligible to colleagues. Some people write a short and a long psych. report. Psychologists should also communicate steps and findings to parents, and be frank with the child.

Sehdev, H., Adapting the Weed System to Child Psychiatric Records". Hospital and Community Psychiatry, 1974 (Vol. 25) pages 31-32

Notes drawbacks of traditional use of problem-oriented recordkeeping methods - focus on problems not strengths. Paper describes adaptation of system at Children's Division of Menninger Clinic. Treatment plan rationale, flow sheets of medical/dental/medication activities.

Stoeffler, V. R., Meyer, R. and Smith, D. C., "Lessons to be Learned from New Child Health Programs: Where Do We Go From Here?". American Journal of Public Health, 1972 (Vol. 62) page 114

Paper describes organizational patterns developed in child health programs which show promise. Important to use multidisciplinary team and allied health professionals from community. Need for skillful referral from one staff member to another. Mutual understanding of roles from each team member. There must be agreed upon plan of management which spells out objectives of care and timetable. In this way, duplication can be avoided.

Thompson, R., et al "A Model Interdisciplinary Diagnostic and Treatment Nursery". Child Psychiatry and Human Development, 1974 (Vol. 25) pages 224-232

Description of a diagnostic and treatment program for developmentally disabled children using multidisciplinary team. Children seen in clinical-educational nursery. Process of assignment is described. Use of problem-oriented methods. Specification of objective problem list and treatment goals.